

# THE MEDICAL EXAMINER,

## And Retrospect of the Medical Sciences.

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### A COURSE OF CLINICAL LECTURES,

*Delivered at the Hôtel Dieu, Paris, for the Session  
1842-'43.*

BY A. F. CHOMEL, M. D.

#### LECTURE VIII.

#### ILIAC ABSCESS.

I shall to-day, commenced Dr. Chomel, direct your attention to the interesting subject of those purulent collections which occur in the iliac region. Three cases of this kind have lately presented themselves to our notice in these wards. One terminated fatally last month; and the other two are still in the hospital.

**CASE I.**—*Post puerperal peritonitis—Consecutive iliac abscess—Spontaneous perforation—Acute peritonitis—Death.*

In the course of last month you may remember a patient at No. 29 of the Salle Saint-Bernard. This woman entered the house with symptoms of acute peritonitis. She had been recently delivered, and imprudently left the *Maternity* three days after her confinement. She was almost immediately seized with pain in the abdomen, with general malaise, and fever. When she was admitted, on the 17th of December, she suffered a great deal from pain in the hypogastric region; pressure there was very painful; and the uterus was felt quite voluminous. There was want of appetite, with fever; there was, in a word, post-puerperal peritonitis, an affection much less grave, as you know, than puerperal peritonitis, properly so called. This affection was combatted by general bleedings, by the application of leeches on the seat of pain, by poultices, and by revulsives to the intestines. Under the influence of this treatment, the general and local condition was ameliorated; but at the same time an acute pain was developed in the right iliac region; then an elastic tumor appeared, which was distinctly felt by pressing firmly on this region with the fingers. The abdominal parietes were stretched, and could be depressed with difficulty; the sensibility was very much exalted, and the fever reappeared. By these symptoms it was not difficult to recognise a phlegmonous tumor situated in the cellular tissue of the iliac fossa.

These kinds of tumors increase towards the pelvis sometimes, and point towards the external organs of generation, particularly in the vagina. Hence, on carrying the finger into this canal, and pressing on the prominence of the tumor, you can distinguish very easily, especially if you take the precaution of pressing at the same time with the other hand on the iliac region, where the principal seat of the tumor is; and by this means, too, you can ascertain fluctuation. You can also, in this case, with advantage, join to the examination per vaginam that by the rectum also; by means of this latter mode of exploration, you are

enabled to circumscribe the tumor perfectly. We have employed these different methods of examination in our patient, and we have been able to distinguish nothing in the vagina, nor in the rectum, and we concluded, therefore, that the tumor was limited to the iliac region, and that, as yet, the suppurative process was not established.

Most generally these tumors terminate by suppuration; and you see them in that case, after having run through all the phases of abundant suppuration, give rise to symptoms of purulent resorption. Fever occurs, diarrhœa follows, the cerebral phenomena manifest themselves, and the patient soon succumbs. You can, in such cases, foresee the lesions which the autopsy will reveal.

Occasionally these phlegmons are resolved; but to obtain this result you must act from the beginning with great energy, by direct and indirect antiphlogistic means, and by revulsives. You sometimes see under the influence of this treatment the pain cease, the tumor gradually diminish to the size of a small nut, and finally, after remaining so for some time, entirely disappear. When a phlegmonous tumor terminates by suppuration, the pus may diffuse itself, and take different directions. I have seen it point sometimes in the intestines, at other times in the vagina or the bladder, giving rise to a series of symptoms which alone would show the existence of a new affection. But methodical palpation made upon different parts of the abdomen, the pain which occurs when the implicated parts are pressed on, put the physician on the track of the disease he has now to deal with. When you suspect the complication I have just indicated, you should recommend the patient or the nurse to preserve the urine and the stools; you will explore, too, the vagina and rectum carefully, and you will in this manner ascertain if these organs are implicated.

From the commencement I suspected the development of the consecutive affection in question. To confirm these suspicions the urine and the fecal matters were carefully preserved and watched, but no trace of pus was discovered in these excretions, and we were convinced that all the disease was limited to the iliac fossa. Injections of marsh mallows were thrown into the vagina, and leeches, with poultices, were applied over the seat of the tumor. The pain ceased, there was sensible diminution in size, and a little slightly elastic swelling remained, in which resolution went on slowly from day to day. The appetite returned, the strength gradually improved, and all led us to hope that all trace of the disease would in a short time disappear.

On the 9th January, having up to that period continued to do well, she was suddenly seized with severe febrile symptoms, loss of appetite, and general prostration. We suspected the occurrence of suppuration in the tumor of the iliac fossa, but we waited until the morbid phenomena became more marked. Two days after she was taken with a violent, tearing pain in the abdomen, with immediate alteration of countenance,—the tongue became dry; the lips violet; the pulse exceedingly frequent, (from 150 to



160;) the skin cold; there were repeated vomitings, which were very exhausting. She had been very restless the night preceding. In a day or two the iliac fossa became very much swollen, and pressure upon that region gave great pain; all the symptoms, in fact, of a very grave acute peritonitis were developed. Now, what had occurred to develop this peritonitis? Two causes may be suspected; either that the inflammation spread from the iliac tumor to the peritoneum, or, that there had been rupture of the cyst, and effusion of its contents into the peritoneal cavity. The first hypothesis seems to me but scarcely supposable, for a peritoneal inflammation developed in this manner would not be announced by symptoms so severe and alarming; it would have supervened more slowly, and with less violence. It is much more likely that the peritonitis in this case resulted from the effusion of fluid into the abdomen, in consequence of rupture of the iliac tumor. The prognosis was of course exceedingly grave, and we had every reason to believe that the disease would terminate speedily in death. What was to be done in the face of this new complication? Our only resource was a purely palliative treatment, which would assuage as much as possible her sufferings, remove everything which would produce any movement in the patient, augment her pains, or aggravate her condition. On this account we did not order even enemata; a little magnesia was prescribed, rather as a modifier of the gastric state than as a purgative.

On the 10th there was some improvement; the pulse fell from 150 to 120, and finally to 104. In spite, however, of this, we still regarded the condition of the patient as very desperate. She was always oppressed; an abundant, cold, clammy perspiration bathed her whole body; her pulse was small, and very compressible; her countenance was very much changed; the abdomen remained painful; the bilious vomitings continued; no alvine evacuations. The treatment now ordered consisted of mercurial frictions, iced drinks, with calomel in doses of sixteen and eighteen grains, with the object of removing the gas collected in the intestines, and to unload the rectum. Under this treatment there was decided amelioration. The flat sound, which had occupied a large portion of the abdomen, became limited to the hypogastrium. We supposed the phlegmon limited to this part; and for the purpose of assuring ourselves we made an examination per vaginam.

On introducing the finger into the vagina as far as possible, I was able to detect superiorly and posteriorly an elastic point. Believing in the existence of a purulent collection into the recto-vaginal wall, I introduced a finger into the rectum, but this exploration revealed nothing peculiar in this region. On pushing the finger as far as possible, I thought that I perceived towards the pelvis a kind of hardness, tumefaction, or œdema, which led me to suspect that the peritoneal inflammation was circumscribed to the inferior portion, had reached the pelvis, and tended to point through the intestine. In this belief the nurse was ordered to preserve the urine and stools. The next day we noticed on the surface of the matters in the vessel a thick coat of pus, of a reddish hue, and streaked with blood. Thus we had incontestable proof that the abscess had opened into the intestine. Now, how did this happen? Did the pus enter directly the intestine from the abscess, or did it do so through the medium of the peritoneum? It is difficult to decide rigorously this question; but it appears to me most probable that the pus passed from the iliac abscess into the peritoneum, and from

thence into the intestine, and that there was no direct communication between the purulent collection and the intestine. It is also probable that the pus of the abscess, in reaching the peritoneum, excited suppurative inflammation in that membrane, after the recognised fact that pus produces pus; and that the pus which is now discharged from the intestine is derived in part from the abscess, but in greater part from the peritoneum itself. This is a fact very remarkable in this point of view, and one that should be noticed. At this period the hypogastrium was flat, nearly as much so as the epigastrium, whilst previously it was very salient. The intestinal convolutions, which were well defined, and prominent beneath the integuments, also disappeared; in fact, a very great change for the better occurred. But still, the patient was very far from being out of danger. The pus, although having an outlet through the intestine, could stagnate in some point; the walls of the cavity would remain open, and consequently the abscess would not be entirely emptied; and from thence all the consequences of purulent resorption and its results might be anticipated; so that, with all the actual amelioration in the patient's case, the question of the issue of the disease was very far from being settled. This state of improvement, in fact, did not last; the inflammatory symptoms reappeared in the hypogastrium, and the patient sank.

The autopsy showed us manifest traces of peritonitis; there were filamentous adhesions between the intestinal convolutions, passing from one convolution to the other, and which could be easily torn. At the inferior part of the abdomen there was a pouch containing a tumblerful of pus. We found also pus effused into the cavity of the pelvis. Evident traces of inflammation existed, too, in the broad ligament of the right side; it was in this part that the phlegmonous inflammation commenced and the abscess was formed, to discharge into the peritoneum, and from thence into the cœcum. In this part of the intestinal canal there was a perforation large enough to admit the finger, through which the purulent matter contained in the cavity of the peritoneum passed, and then passed out through the rectum. If the perforation had happened through the rectum instead of the cœcum, the chances of a favourable termination would have very much increased.

The uterus offered also evident traces of inflammation; at some points, indeed, it was gangrenous; this alteration was at a level with the primitive abscess, and is very remarkable.

*CASE II.—Abscess in the left iliac fossa—Development of another similar one on the right side—Symptoms of hectic fever—Convalescence.*

At No. 5 of the same ward is a patient whose history presents a great deal of analogy to the preceding one, and who offers some interesting points relative to the subject that we are now considering. This woman, who is twenty-five years of age, entered the Hôtel Dieu about six months since. She told us that she had never had children. In the left iliac fossa there was a tumor, very appreciable on palpation. This tumor was accompanied with pains, and symptoms of febrile reaction. Twenty-two days after, the patient passed with her urine some pus, which induced us to think that the abscess had pointed into the bladder. This woman remained for some weeks in the house, where she was submitted to appropriate treatment, which principally consisted in methodical compression over that part of the abdomen which we considered the seat of the abscess.



with the object of inducing adhesion of the walls of the cyst. She left the hospital on the condition of continuing the use of the bandages until the cure was complete.

Eight days since this woman was again seized with violent pain in the right iliac region, with chills, and a general state of *malaise*, to such a degree as to be obliged to return to the hospital. This time we examined her case with great attention. By touching, we discovered nothing abnormal in the uterus, which retained its natural mobility. There was some sensibility, on pressure, in the iliac region, but no appreciable tumor. Some days elapsed without the occurrence of other symptoms; but we soon began to perceive traces of pus in the urine, and its existence there was confirmed by an analysis of M. Bouchardat. We concluded, then, that an abscess was developed in the right iliac fossa, similar to the one which had previously existed on the left side. On examining again *per vaginam*, we found the uterus increased in volume, without suppression of the menses, which removed all idea of pregnancy. The patient told us that she had seen, for some time past, a thick, whitish cloud in her urine, formed by a creamy substance, which we did not hesitate for an instant to recognise as pus. From all appearances the purulent collection in the left side, which had existed six months before, had never completely closed, and the pus still continued to be discharged into the bladder, as before. It is extremely rare to see iliac abscesses remain open for so long a time; still, some examples are found in the annals of our science, and I have met with some cases in my own practice. The principal phenomenon or symptom which enlightens, in these circumstances, the physician, upon the affection which he has to deal with, is the presence of pus in the urine, or in the fecal matter.

A number of curative measures have been suggested in such cases. These means consist chiefly in the use of douches in the abscess, with the double object of cleaning out the purulent cavity, and getting rid of the pus, which might occasion subsequent grave accidents, and to dispose the cyst to heal.

Abscesses of the pelvis require, above all, the employment of compression, when the cyst persists in remaining open. All practitioners who have had much to do with this affection agree in this respect, and I myself have frequently had occasion to acknowledge the utility of the practice.

Boyer, under similar circumstances, recommended to a woman laboring under a rebellious iliac phlegmon, which would not cicatrize, to become pregnant. She did so, and was cured. You can easily understand, in this instance, how the pregnancy affected the cure; the gravid uterus exercised compression upon all the surrounding parts, thus favouring the adhesion of the sides of the abscess.

Our patient first presented an inflammatory affection, followed by a phlegmon in the left iliac region, which opened into the bladder. This patient has never been pregnant. A mild antiphlogistic treatment easily overcomes the uterine phlegmasia, but does not arrest the progress of the iliac abscess, and the patient leaves the hospital the first time alleviated, but not cured; for, for some time subsequently, as we have seen, pus continues to be found in the urine. Pain is subsequently felt in the right iliac region, and all the symptoms of the first affection appears on the opposite side. In the present case the most energetic means were employed, with, however, great fears for the result. For three weeks she continued in the same state; and, at the end of that time she was rather worse. She suffered a great

deal in the hypogastric region. The urine continued to contain always the same quantity of pus, (about half an ounce,) of reddish-grey colour.

Eight or ten days subsequently the fever increased, and the volume of the uterus augmented; the hypogastrium became more painful on pressure; the general symptoms were aggravated; whilst, on the other hand, pus ceased to be discharged, until nearly every trace of it vanished. It has been remarked that in these affections, whenever the general symptoms increase, and the local pain becomes more intense, the quantity of pus diminishes, and *vice versa*; on the reestablishment of the purulent discharge the accidental phenomena cease, and the patient returns again to the same state as before. De Halle first remarked this coincidence. This aggravation of the general and local symptoms led us to suspect a retention of pus in the abscess. But the pus in a short time reappeared; and this time, in place of being discharged into the bladder, and appearing in the urine, it was discharged through the rectum. In the vessel, and in the matters contained in it, there was an ounce of pure pus, mixed with the solid fecal matter. Nearly immediately after the reappearance of the pus the pulse fell to about seventy or seventy-five, the hypogastric pain diminished, and the patient demanded something to eat. We endeavoured to discover the point at which the pus reached the rectum. On examination *per vaginam*, I detected a doughiness, indicating a tumor, at some distance. The rectal examination, by means of which much more light could have been thrown on the nature of the local affection, was rendered almost impracticable by a fissure which existed at the margin of the anus.

After some days, however, on proceeding with great caution, we were enabled to introduce the finger a sufficient distance to explore the whole region, but were unable, in spite of all the care used, to distinguish the spot in the rectum at which the pus penetrated.

Enemata were ordered, which had the double advantage of washing out the abscess and maintaining the intestine free.

On the 7th January there was decided amendment; no more pus was discharged by the rectum, although the urine continued to be somewhat troubled. The same treatment was continued, with much methodical compression. From this time convalescence proceeded rapidly.

There was, however, towards the latter part of the month, a return of the febrile symptoms, with abundant nocturnal sweats, which occurred principally about daybreak. In spite of this the appetite continued good. These phenomena, which so frequently occur in bed-ridden patients, are often referrible to the existence of tubercles. It is that, at least, which you most commonly see in hectic fever without any new appreciable cause. It must be acknowledged, however, that hectic is not always the result of tubercularization; it may be the effect of extensive suppuration, which is certainly its cause in the present instance. Our patient has had extensive and deep suppuration, which was discharged both into the bladder and the rectum; the pus then ceased to be discharged by these artificial means. Now, it is possible that there is some pus remaining in the abscess, which causes the hectic fever. Deep seated abscesses of the abdomen often occasion this febrile state; and the prudent physician, before proceeding to pronounce upon the existence of tubercles, will duly consider all the circumstances which can explain the existence and persistence of hectic.



In this state the patient continues. She passes occasionally a few drops of pus in her urine; the diarrhoea is arrested. Finding that her prolonged stay in the hospital would have an unhappy influence upon her *morale*, we shall give her a discharge, recommending her to be particular in her diet, and to let it be as nutritious as possible. It may be hoped that, as she gains flesh, the sides of the abscess will adhere, and that a radical cure will take place. Without this condition, on the contrary, a relapse will be likely to occur.

CASE III.—*Iliac phlegmon terminating by resolution.*

At No. 38 of the same ward, in the next bed to this patient, is another woman, about thirty years of age, who entered the service on the 28th of October. On her entrance she had erysipelas of the face, and at the same time she complained of violent pain in the hypogastric region, principally in the right side. After suitable treatment the erysipelas disappeared, but the fever continued, as well as the local abdominal symptoms. On exploring the abdomen carefully we distinguished an oblong tumor, moveable under the finger, and sensible on pressure. It was a phlegmon in the right iliac region. A vaginal exploration revealed nothing to us in that quarter. The treatment was nearly the same as in the other case. After having exhausted the antiphlogistics, (bleedings, baths, cataplasms,) we recurred to resolatives, to mercurial frictions, and by these means succeeded in reducing the tumor about one-half, and rendering it less hard and less sensible to pressure. In the mean time the general and local symptoms disappeared; her diet was improved; her appetite and digestion are good; and there is every reason to believe that her recovery will be definitive.

SULPHATE OF ALUMINA AS AN ANTISEPTIC.

[We have been handed the subjoined letter for publication. It is additional evidence of the utility of the Sales Aluminæ.—Ed. M. Ex.]

PUTNAM COUNTY, GEORGIA, May 1st, 1843.

DEAR DOCTOR,—It affords me much satisfaction to see, at your suggestion, the article Sulph. Alumina put to the test, as an antiseptic and detergent, and those properties fully and unequivocally accorded to it by numerous trials in the surgical wards of the Philadelphia Hospital. In corroboration of your views in relation to the antiseptic properties of the Sulph. Alumina, I will merely state to you that I have been using that article as an astringent and antiseptic in foetid vaginal discharges, (from all causes, except its use was absolutely contra-indicated,) with the happiest effect, for the last six years; it has invariably corrected the foetor in a short time. It first suggested itself to me as an antiseptic after using it in a case of abortion with retained placenta, succeeded by sanguineo-foetid discharge, which was very soon corrected by its use as an injection. The strength of the solution has been made in accordance with the sensibility of the parts.

Yours, respectfully,  
G. JOHNSON.

Robley Dunglison, M. D.

CASE OF A NEEDLE ENTERING THE RIGHT BREAST,

*And finally lodging in the heart, causing death.*

By B. F. LEAMING, M. D.

Physician to the Philadelphia Dispensary.

On the 4th of August, 1842, a seamstress, in good health, eighteen years of age, came to my office, requesting me to remove a needle which she supposed had penetrated the right breast. Two days before, while in the act of bending suddenly forwards, she had struck a table, and driven a needle, which was sticking in her dress, forcibly into the breast. She was not quite certain that the needle was still there; sometimes she thought she could feel it, at other times she was sure it was not there. On examination I found a puncture about an inch from the nipple, a little below the margin of the areola, and on the side towards the sternum. Her breast was rather large; it could be pressed firmly in any direction without causing pain; she had no cough, and could take full inspirations without inconvenience.

On the 8th of September she had pleurisy of the right side; she had not been exposed to cold, but the pain and cough and difficulty of breathing had come on suddenly after she had stooped to pick something from the floor. The inflammation yielded to the usual antiphlogistic remedies, and in three weeks she regained her usual health.

On the 13th of February, 1843, she had a slight attack of pneumonia of the lower anterior part of the right lung; she had also bronchitis on both sides. She recovered in a week from the acute symptoms, though afterwards she was always affected with a troublesome cough.

On the 10th of March she had spasms of the diaphragm; they continued for three or four days, intermitting occasionally for a few hours. The inconvenience was not sufficient to confine her to the chamber. Until this time the pulse had been regular, and always corresponded to the degree of fever present.

On the 26th of March she had obstinate vomiting, not accompanied by tenderness at the epigastrium, nor by thirst for cold drinks, nor by constipation, nor by any cerebral symptoms whatever. The vomiting continued four days; it was always increased by drinks, though the efforts frequently persisted while the stomach was quite empty. During the intervals her pulse was 80, feeble and regular.

On the 5th of April she had pain in the heart. During my attendance at the previous illness of the patient, my prescriptions had been so much neglected that I declined visiting her any more; therefore I did not examine her symptoms particularly when called on at this time, (5th of April,) but requested the friends of the patient to seek advice elsewhere.

On the 8th of April she was visited by Dr. Franklin Bache, who detected the existence of pericarditis, accompanied by a very irregular and feeble pulse. From inattention on the part of the patient to Dr. Bache's prescriptions, his visits were continued only four days. She was then attended by Drs. Watson and Arrott, who found her in a very prostrate condition, with irregular pulse, and sometimes so feeble that it could scarcely be felt; she had also the usual symptoms of pneumonia.

On the 15th of April she had œdema of the feet; and two days afterwards her face was somewhat swollen.



She died on the 27th of April, nearly nine months after the needle had entered her body.

On examination, after death, the right lung was found adherent throughout to the costal pleura; both lungs were congested, and the bronchia inflamed; at the posterior inferior part of each lung there was some hepatization. The pericardium contained more than a quart of fluid blood; its surface was covered with deeply reddened lymph; some of the recesses formed by small folds of the pericardium, or by adhesions near the upper part of the auricles, were filled with grumous blood; there were adhesions at the under surface of the heart, particularly under the right ventricle, and in a line parallel with, and half an inch from the septum. The heart was small and flaccid, containing only small coagula. On opening the left ventricle the point of a needle was seen protruding a quarter of an inch towards the middle of the cavity. The needle had passed at the under surface of the heart about three-quarters of an inch from its apex, and half an inch from the septum, through the wall of the right ventricle, through a columna carnea, through the septum and into the left ventricle. It was fifteen lines in length; its head, somewhat incrustated, was imbedded in the wall of the right ventricle, just under the surface of the pericardium. The orifice made by the needle seemed to have been completely closed by coagulable lymph; but it would be very easy for a small channel to escape detection in such a mass. The internal membranes of the heart were smooth and shining, without any marks of inflammation; all the large vessels were in excellent condition.

#### Remarks.

Although the patient could never point to the situation of the needle, and was always unconscious of its presence in any particular part, yet, during my attendance, I never doubted that it was the cause of all her ailments. I presume it first lodged obliquely in the intercostal muscles, or was made to do so by her own attempts to discover its situation; it then passed through the pleura, and probably a portion of the lung, reaching the floor of the diaphragm; it then seems to have moved near the œsophagus, irritating some filaments of the par vagum; and finally, it reached the heart.

The blood in the pericardium may have derived either from the cavities of the heart, or from the inflamed adhesions, or from both. In the first case, we may suppose that every contraction of the heart separated the muscular fibres sufficiently to allow the blood to pass along the sides of the needle; and the separation of the fibres of the walls of the right ventricle would be greatly favoured by the working of the needle, caused by its extremities being subjected to differently acting forces. It is true no channel through the adhesions of the pericardium could be detected; but in the relaxed condition of the heart a small channel through coagulable lymph would necessarily escape detection. From whatever source it derived, the blood was of good appearance, resembling that drawn from the arm of a moderately anemic person; it therefore could not have been much diluted by serum from the inflamed pericardium.

#### SUPPRESSION OF QUACKERY.

The French Chamber of Peers has passed a law ordaining that, in future, no patents shall be granted for secret remedies or for pharmaceutical preparations.

## CLINICAL LECTURES AND REPORTS.

### A LIST OF CASES

DISCHARGED FROM THE SURGICAL WARDS OF THE PENNSYLVANIA HOSPITAL,

*During the month of April, 1843.*

[Reported by ELLERSLIE WALLACE, M. D., Resident Surgeon.]

One case of injury from machinery, all the toes of the right foot being torn off. Under treatment 113 days.

Discharged, cured, the stump being smooth and healthy.

Two cases of ophthalmia. Under treatment sixty-four days.

Discharged, cured.

Two cases of paronychia. One under treatment fifty-four days, the other, thirty days.

Discharged, cured.

One case of onychia. Under treatment twelve days.

Discharged, cured.

Six cases of contusion, in four of which the injury was trifling, and the patients were discharged, cured, in from two to nine days. One case occurred in an old man, of bad constitution; severe contusion of the left knee. He was under treatment seventy-two days, and then was discharged, cured. One case, in a young man who had fallen prone, and whose loins had been passed over by a loaded cart. Admitted twenty-two hours after the accident. No fracture could be discovered, and motion and sensation in lower extremities perfect. His pain was very great, and any motion of the pelvis increased it. Abdomen hard, and very tender on pressure; tympanitis slight. He had had repeated vomitings for the last few hours, which still continued. Neither urine nor fæces had been passed since the injury. Pulse 88, and feeble. After the catheter had been passed an enema was given, with the effect of opening his bowels freely, and cut cups were applied to lumbar regions and spine. A large emollient poultice was applied to the abdomen, and a sinapism to the epigastrium. Ice in small pieces was ordered, to allay his thirst, which was intense. No medicine could be retained by the stomach for a sufficient length of time to be of any service. Under the treatment he was more comfortable after the lapse of an hour, with less frequent vomiting, and less soreness on pressure. During the night he passed his urine four times, and in the morning appeared a little better. At 8 o'clock, A. M., the vomiting became more frequent, the thirst also increased; and at 9 o'clock, eighteen hours after his admission, he was seized with symptoms of peritonitis. The treatment now instituted consisted chiefly of full venesection, followed by an enema and hot stupes to abdomen. For a short time his pain was relieved, but it soon returned with increased violence; and at 5 o'clock, P. M., twenty-six hours after his entrance into the hospital, he died. An autopsy was asked for, but refused.

One case of sprained ankle, caused by a fall down the hold of a vessel. The constitutional treatment instituted was antiphlogistic, and the local treatment adopted was rest, elevation, and cold lead water poultices applied to the part for several days. Afterwards a soap plaster and bandage were used, and after thirty days he was discharged at his own request, nearly well.



One case of rupture of external lateral ligament of the knee. Under treatment 105 days.

Discharged, cured.

One case of fracture of the os humeri in its lower third. Treated by a bandage from the ends of the fingers up to the axilla, and an angular splint on the inner side of the upper extremity, extending from the axilla to the ends of the fingers; and a short straight splint on front, back, and outside of the arm. Under treatment thirty-two days.

Discharged, cured.

One case of fracture of the olecranon process, without much displacement. Treated by a splint applied to the front of the upper extremity, keeping it in the extended position, with a bandage from the ends of the fingers up to the axilla, having a figure of 8 turn at the elbow to retain the olecranon in place. Under treatment forty-five days.

Discharged, cured.

Three cases of fracture of the lower third of the radius. Treated by a splint on front and back of the forearm, extending to the ends of the fingers, with compresses to retain the fragments in apposition. In from forty-two to fifty-nine days all were

Discharged, cured.

One case of fracture of the patella in a lad seventeen years old, caused by muscular contraction. Separation one and a half inches. Treated by a straight splint to back of lower extremity, keeping it in the extended position, with a bandage from the foot up to the groin, having a figure 8 turn at the knee to keep the fragments in apposition.

Under treatment eighty-nine days. Discharged, with a ligamentous union one-third of an inch long. Motions of flexion and extension of leg increasing slowly.

One case of fracture of the leg. Fibula broken near the upper end, and both bones broken in the middle third, caused by a fall of coal in a mine at Pottsville, Schuylkill county, Pennsylvania. The fracture was reduced soon after the accident, and he was sent by railroad to Philadelphia; the leg being secured by splints and a bandage. Upon the removal of the dressings the soft parts were found to be severely contused, and the swelling and irritation were very great. Violent inflammation followed, with the formation of an extensive abscess, by which the fracture became compound. The constitutional symptoms were very severe, requiring careful attention and support. The leg was treated in a fracture box, and after being under treatment ninety-four days, he was

Discharged, cured.

One case of compound fracture of the skull, with depression, caused by a fall from a horse. When admitted, the man was labouring under symptoms of concussion of the brain, but could answer questions satisfactorily, and assisted in taking off his clothes. He had been bleeding from the right nostril since the injury, but the hemorrhage had ceased before he was brought in. There was no hemorrhage from the ears. The left eye was somewhat prominent, and the lids largely ecchymosed; but no contusion could be discovered near the eye. The fracture was over the coronal suture, midway between the sagittal and squamous sutures, about an inch long, and the depression slight. The wound of the scalp was somewhat less than an inch in length. His hands and feet were cold; his pulse 50, and rather feeble. Sinapisms were applied to his ankles and feet, and over the abdomen, and in less than an hour reaction came on violently, with well marked symptoms of compression; strong spasms, and face almost livid;

the blood was also flowing from the nostril; his pulse was 52, and full and strong, and his respiration loudly stertorous. He was freely depleted, by which the spasms abated; his face became more natural, and also his respiration. His pulse rose to 58, and became much softer. The relief, however, was but temporary; the unfavourable symptoms soon returned, and in three hours from the time of his admission he died. An autopsy could not be obtained; but it is probable that a greater injury existed than the one above mentioned. The symptoms were very similar to those observed in a case which occurred in this city about a year since, in which a post-mortem examination showed an extensive fracture of the base of the skull.

One case of caries of the spine and bones of the pelvis and lower extremity, with extensive tuberculosis of the lungs. Cavities had been formed in the upper lobes of both lungs. There was also found a psoas abscess, with a large quantity of pus and cheesy matter under the muscle, and a large cold abscess on the outside of the thigh, communicating with the hip-joint. Tubercles of considerable size were also found on the bones. The patient was a man about twenty-seven years old, and had been in the Hospital but three days at the time of his death.

One case of erysipelatous inflammation of the arm, following a cut of trifling size, received four days previous to his entrance. The arm was swollen and very painful, and the patient had some fever. He was put in bed; purged with Pil. Hydrarg. and Sulph. Magnesiae; ordered a low diet; and lint, wet with cold mucilage, was laid over the arm. After being under treatment two days, he was, at his own request,

Discharged, much better.

One case of axillary abscess, extending far under the great pectoral muscle. Opened four days after his admission. Under treatment fifteen days.

Discharged, cured.

One case of inflamed face. Under treatment ten days.

Discharged, cured.

One case of furunculus. Under treatment twelve days.

Discharged, cured.

One case of ulcer of the leg, resulting from contusion on the spine of the tibia. Under treatment thirty days.

Discharged, cured.

One case of ganglion on the dorsum of the foot. Treated by punctures and compression. Under treatment forty-four days.

Discharged, cured.

From the venereal wards there were discharged four cases, one of which had been under treatment for a large cluster of venereal warts. By the knife, and repeated applications of the pure nitric acid, they were entirely removed; some thickening of the prepuce remaining, the part was rubbed with ung. hydrarg. camph., with the effect of producing absorption of the lymph, and he was

Discharged, cured.

Besides the above, the following cases were treated, and went out, by their own request, immediately.

Five cases of incised and lacerated wounds of the scalp.

Three cases of incised wounds of the upper extremity; and



One case of a woman who had swallowed a large pin. The head could be felt by the end of the finger, and the pin had penetrated the posterior part of the larynx. It was removed by a pair of polypus forceps.

## THE MEDICAL EXAMINER.

PHILADELPHIA, MAY 27, 1843.

### MEDICAL ETHICS.

We understand the College of Physicians of Philadelphia has been occupied recently, at several of its meetings, revising the by-laws which govern its fellows. Such a revision and emendation are perhaps necessary—we say perhaps, because we are by no means certain that corporate bodies add anything to their dignity or influence by devising rules or laws which they have no power to enforce upon those to whom they may be applicable. It is the opinion of some very respectable persons, that one of the chief defects in the operation of our political system is, its superabundant, hasty, and imperfect legislation. If the College of Physicians of Philadelphia were vested with power by the State legislature, to regulate the practice of medicine and surgery throughout the State of Pennsylvania, or even in the county of Philadelphia, it might enact salutary and effectual rules, beneficial to the members of the medical profession, and still more advantageous to the people of Pennsylvania. How far the creation of rules, which have merely the force of the opinion or declaration of the college, may influence the profession generally, must depend upon the sound, common-sense principles they embody.

The rules proposed for adoption by the college have been printed; and among them is the following:

"24. [XI.] A regular collegiate medical education furnishes the presumptive evidence of professional ability; and is so honourable and beneficial, that it gives a just claim to preëminence among physicians, in proportion to the degree in which it has been enjoyed and improved. Yet, as it is *not indispensably necessary* to the attainment of knowledge, skill, and experience, they *who have really* acquired, in a competent measure, such qualifications, without its advantages, should not be fastidiously excluded from the privileges of fellowship."

What is the substance of this declaration, and what is to be its tendency?

First; it asserts that it is highly respectable to have the degree of Doctor in Medicine conferred on one by a college or university, and that this diploma or certificate of "a regular collegiate medical education furnishes the *presumptive* evidence of professional ability."

Second; it declares that "knowledge, skill, and experience" in medicine may be attained without "a regular collegiate medical education;" consequently, those persons who have *really* become *knowing, skilful, and experienced* practitioners, without "a regular collegiate medical education," should not be considered inferior to those who have gained a diploma, and "should not be fastidiously excluded from the privileges of fellowship" of the College of Physicians?

If a "regular collegiate medical education," vouched for by a collegiate diploma, be only "presumptive" evidence of professional ability, what is the presumptive or positive evidence of professional ability to the people, or members of the College of Physicians, in practitioners who have no regular medical education, but who have "picked up" their knowledge hap-hazard or intuitively, or who are doctors by virtue of the seventh male descent. In a word, by what test, or by what means, is the college or any one of its members to discriminate between self-styled doctors and legally commissioned practitioners? How is it to be determined "who have *really* acquired, in a competent measure," the qualifications—"knowledge, skill, and experience"—without a regular medical education, that shall entitle them, on any ground, to "the privileges of fellowship" with the whole medical profession? Are they to be formally or otherwise examined by the college, or by a member of the college? or, is the question of competency to rest upon common rumor—the voice of the people? If the latter testimony be taken as presumptive of "professional ability," unless they should "be fastidiously excluded from the privileges of fellowship," homœopaths, Thomsonians, mesmerists, the St. John Longs of the day, and the venders and advocates of "red drop," and Devere's specific, may be all, one day, numbered among the fellows of the College of Physicians? They should not be "fastidiously" excluded because they keep a professional card in a newspaper, merely stating the locality of their office, or because their names may be attached to a popular remedy? What is the virtual difference in the merit or demerit attached to the individuals whose names designate a remedy or an instrument? We once heard this expression,—"*I mean Wistar, the lozenge man!*" and although it sounded gratingly upon our ears, it occurred to us that the public, especially where the individuals are not known, must regard "*Wistar, the lozenge man,*" Sherman, the lozenge man, Wright, Brandreth, Morrison and Lee, the pill men and panacea men, as equally entitled to its consideration and confidence? What is the difference between Sir Astley Cooper and Dr. Hull in this respect? Why should it be, in the eyes of any College of Physicians or Medical Society, honourable to Sir Astley Cooper to have a knife designated by his name, and at the same time disreputable for another surgeon to have a truss known by his name? Because the inventor of the truss derives peculiar advantage from it through a patent, while the inventor of the knife gives it to the whole profession, without tax or hindrance of any kind. But the same inventor of the knife thought himself entitled to peculiar advantages for his lectures and teachings, and consequently laid an injunction upon the publishers of what is commonly known as the "pirated edition" of Sir Astley Cooper's lectures. Why shall a man be allowed the advantages of patent right for a book he may write, but be disgraced among his professional brothers, if he claim a share of the profits arising from an extensively useful instrument of his own invention? And will the college "fastidiously" exclude from the privileges of fellowship those who have "the presumptive evidence of professional ability" in "a regular collegiate medical education," because they hold a patent for an instrument of their own invention, and take in as fellows the irregularly instructed practitioner who has invented nothing?



The tendency of this article of the proposed by-law is to discredit universities and colleges, and regular medical education. While we admit that knowledge and skill may be acquired without resorting to the halls of a college, we believe that instances of the kind alluded to are rare; for this reason it would be much better to exclude from the privileges of fellowship with the profession, all those who do not possess formal and legitimate evidence that they have acquired a "competent" knowledge of the science and principles of the healing art. This admission that a regular medical collegiate education "is not indispensably necessary to the attainment of knowledge," is calculated to lower the standard of information which has been already brought too low by the competition of the medical schools—a competition in reference to the number, and not the competency of the graduates—and the consequence is, that the public is rapidly losing confidence in the value of medical diplomas; a higher though more uncertain test is required—popular favour; and for the service of the army and navy, scrutinizing examinations, which are much more likely to be authentic tests of professional qualification.

Before we can determine what description of practitioners should be admitted to the privileges of fellowship, it would be well to define, as nearly as may be, what qualifications and attributes constitute a physician, and then what testimony shall be considered as sufficient to satisfy us that the aspirant is worthy of the title. There should be some high standard set up that cannot be overturned by pecuniary considerations—and perhaps, under the present system of instruction, no college that is supported by fees from students has wealth and influence enough to require very high qualifications for its diploma. But the College of Physicians of Philadelphia, or any similar institution in the United States, might create a standard that it would be highly honourable to be successfully measured by. There must be a line drawn somewhere, to separate the irregular practitioners and empirics from the regularly educated physicians, or in a very few years the public will not distinguish learned and high-toned physicians from advertising doctors:—the latter persons may say, it is true I never received medical instruction at any college, but you know, knowledge, skill and experience, can be as well acquired out of a college as in it; and I had no money to throw away upon professors: besides, I am as capable of treating disease, and living by my practice, as the most learned and fastidious among them.

With proper deference to the joint wisdom of the college, we are of opinion that the article 24 is neither judicious nor politic, in its present form.

There is another article (33) which ought to be entirely omitted, or given in an opposite sense. It is as follows:

"33. [XVIII.] Ministers of the gospel should be attended gratuitously by the faculty. This is the acknowledged rule; but such of the clergy as are qualified, either from their incomes or fortunes, to make a reasonable remuneration for medical attendance, are not to be more exempted than any other order of patients."

According to our experience, there is no class or calling, taken as a body, better able to pay physician's bills, and no class of men more ungrateful for medical attendance than the clergy. And what is equally worthy of

remark, there is no class of men who do more to sustain medical quackery than ministers of the gospel. We have known a clergyman to introduce a professed electro-magnetist to a patient who was, to the clergyman's knowledge, receiving the professional attentions of a respectable practitioner, and countenance a proposal that electro-magnetism should be resorted to without the knowledge of the physician!

Another clergyman—a popular divine—circulated pamphlets among his sick parishioners, lauding the infallible efficacy of brandy and salt. Some advocate homœopathy and its kindred delusions, and others squint in favour of surgical quackery. While we feel pity for this exhibition of mental weakness, and find a disposition to pardon it on the plea of morbid benevolence, we do not think that the simple fact of a man being a minister of the gospel entitles him to the gratuitous services of any physician for himself or family.

The services of the physician or surgeon are as valuable as those of any other man in the community, and we can perceive no reason why any profession or calling should be more entitled to them than another. Poor lawyers are as much entitled, in our opinion, to gratuitous advice, as poor clergymen;—in short, sickness and poverty, no matter upon what calling they may come together, are claims upon the time and attention that no true physician will pass unheeded. But we are opposed to declaring that clergymen ought to be attended gratuitously by the faculty—for, as a general rule, the favour is not so much to the clergyman, perhaps, as to the congregation over which he presides. And when we see a church making collections to defray the expenses of a European tour for its pastor, it seems to us the same means might pay the demands of the physician. Why should the physician belonging to a congregation be more taxed than any other member of it? He is expected to pay his church dues with the rest, but there is no reason why he should labour as the family physician of the pastorage.

According to our views, it is not the way to sustain the profession, to cut off from its members any legitimate sources of profit. To the great mass of its members the profession is the source of their living—of their bread; and if the course of professional charity is prescribed in this, or in any other way, the actual value of the profession to its members is reduced. The high tone that should grace every medical practitioner must yield, sooner or later, to poverty; and we know of instances where this cause alone has driven respectable and regularly educated physicians to advertise in the newspapers, and, consequently, cut loose from the ethics of a profession that did not give them bread. And what may be regretted by some, their course secured them and their families against starvation.

We think that all kinds of medical certificates, whether for life insurance offices, beneficent associations, exemption from military service, or for pensions, are legitimate objects of profit; but the practitioner should be left to decide for himself the particular cases for charging, and the amount of the fee.\* And, in all cases, the cer-

\* We have heard of a medical certificate that procured for a man, who was in the annual receipt of \$3000, a sum of \$10,000 in hand, and \$300 a year besides. Yet the physician got no fee.



tificate given by a physician should be studiously frank and conscientiously correct, to such an extent that he would not hesitate to make oath that it contained his real and undisguised opinion.

According to the proposed rule, (34.) "These testimonials, unless under particular circumstances, should be considered as acts due to the public, and, therefore, not to be compensated by any gratuity."

May it not be respectfully asked, through what process, or catenation of circumstances, have physicians become debtors to the public, in such wise as to permit this same public to claim their professional services whenever they may be requisite? Does the public set up any claim of this nature over the services of other professional men? Are legal opinions ever required by the public, or by individuals, without acknowledging the right of a fee, at the hands of any persons connected with the administration of the laws, judges, jurors, lawyers, bailiffs or witnesses? Their time and their knowledge are paid for at established rates; and why should a physician be told:—Sir, you must state your opinion to the court as to the health of a jurymen—it is a duty you owe the public, and consequently you are not entitled to remuneration? Or we may even suppose a stronger case. The public requires your opinion, whether an individual died of disease or of violence. Is this opinion of value to the public? Yes; but it cannot be "compensated by any gratuity." Why? The opinion of the judges and jurors is compensated; the public pays the prosecuting attorney, the witnesses, and every body except the physician!

Again: Is the opinion of a physician valuable in cases of life insurance? Certainly. To whom is medical opinion valuable? To the Life Insurance Company! Then, on what principle of equity or justice has that company obtained a right over what is valuable, in form of service—a sort of pilotage—without remuneration? Is it due the public that physicians should labour gratuitously to save the money of Life Insurance Companies?

#### TUBERCLES OF THE SEROUS MEMBRANES.

In a communication published in the "*Archives Générales de Médecine*," M. Briquet, the physician to the Hôpital Cochin, narrates three cases of tubercles and encephaloid tumors on the serous membranes terminating fatally, which occurred in his practice in the hospital, and from which he draws certain deductions.

Bayle was the first who described the formation of these heterologous productions in a precise manner. He mentions the hard and rounded granulations which are formed on the peritoneum as a consequence of chronic peritonitis, and appear to constitute a part of the serous membrane, but can be removed by scraping with a scalpel. He considered them to be merely a transformation of the exuded matter. Broussais and Laennec have also described such cases, as well as Cruveilhier, Andral, Louis, Lombard, and Chomel. As far, then, as pathological anatomy is concerned, these granulations are well known, but much uncertainty and difference of opinion exists among medical men with reference to their pathology, more especially as regards the causes that produce them. By some they are looked upon as a direct effect of inflammation, while by others

they are supposed to spring from the false membranes secondarily, and by a process which has not any affinity with inflammation. It has also been believed that these heterologous productions are found in the serous membranes only after the system has been affected for a long time, and evidently modified by the existence of a similar disease in one of the principal organs. On both points M. Briquet expresses a decided opinion, he regarding the tubercular and encephaloid formation on the serous membranes as the direct result of inflammation, and fully capable of appearing previous to a similar condition obtaining in any part of the organic system. He supports these opinions by the detail of cases which he has treated, and by others selected from the works of Broussais and Andral. That they are the results of inflammation, and that of a chronic character, he concludes, because they are always situate on the free surface of the serous membranes, that they are found almost exclusively on those membranes, which have been the seat of pain and other symptoms of phlogosis, and in the greatest number in that part of the membrane which showed the strongest signs of inflammatory action, and finally; that they do not exist in the false membranes, but spring directly from the surface of the serous membrane, there not being any false membrane in or about them by which they could be enveloped, or of which they might have been a transformation.

Inflammation of the serous membranes, inducing the formation of heterologous productions, is commonly accompanied by dropsy, presenting symptoms and progress so characteristic as to afford a means of diagnosis. The first class of symptoms which present themselves have reference to the phlegmasia, the others to the progress of the effusion. If the disease commence in the chest, there is experienced a more or less severe pain in the side during repose, and on drawing a deep breath; percussion and auscultation next indicate the existence of a fluid in the cavity of the pleura, which is shown by the bronchial respiration, and the modification of the voice, to have been formed very rapidly. If the abdomen be first affected, tension of the parietes is observed, with more or less fixed pain, and constant sensibility on pressure. Dulness on percussion is also experienced in one part of the abdomen, and which continues the same, however the position of the patient be changed. Finally, the tumefaction of the abdomen is irregular, and fluctuation is not perceived until long after the commencement of the disease. The phenomena indicative of the dropsical effusion are equally characteristic, the chief being the long-continued existence of a collection of fluid in the serous cavities, before the occurrence of general anasarca. This state not being in accordance with the usual progress of dropsies, Dr. Briquet thinks it may be regarded as characteristic of the effusion following tubercular or encephaloid disease.

With respect to treatment, M. Briquet is inclined to rely almost entirely on the repeated application of blisters. Tonics and stimulants he has found aggravate the disease, while, although its cause be of an inflammatory nature, the complaint is so modified by the heterologous formations as to admit of the antiphlogistic plan being adopted only as a palliative.—*Provincial Medical Journal*. March 11, 1843.

#### DELIRIUM TREMENS.

M. Sharn has tried, with the greatest benefit, preparations of ammonia in the treatment of delirium tremens.—*Ibid*.



## RETROSPECT OF THE MEDICAL SCIENCES.

## ANEURYSM OF ABDOMINAL AORTA OPENING INTO THE LUNGS.

At a meeting of the Pathological Society of Dublin, January 8, 1842, Dr. Stokes said the specimens he then produced to the society were of great pathological interest; they belonged to a case of aneurysm of the abdominal aorta at the commencement of its course, immediately under or between the crura of the diaphragm, and exhibiting a mode of termination that had not as yet been described. In some cases of this affection the opening has been into the pleura; in others, into the stomach, into the peritoneum, or behind the peritoneum, forming tumors. In the case now communicated by Dr. Stokes, the aneurysm had opened into the substance of the lung; the subject of the case had been first seen by Mr. Pakenham, and subsequently by Mr. Colles and Dr. Stokes. He complained of intolerable pain in the lumbar region, which was aggravated by motion, but relieved by lying with the back towards the fire, or by turning on the face. There was strong pulsation in the epigastrium, and a strong bruit de soufflet or bellows murmur. From all the symptoms, Mr. Pakenham considered the case to be one of aneurysm of the abdominal aorta, in consequence of which the consultation was determined on. Dr. Stokes ascertained that the patient had been complaining for eighteen months, and that he suffered pain of two distinct kinds, one of which was dull and was constantly felt; the other was a violent lancinating pain, which only occurred in paroxysms, often darted downwards into the scrotum, and was not observed for the first time until three months after the other had commenced. The seat of pain was along six vertebræ, the three last dorsal, and the three contiguous lumbar; the pain was increased by pressure on any part of that tract, or by any motion of the spine; a little to the left of the epigastrium was the tumor, in which could be felt a pulsation, evidently coincident with the diastole of the heart; when deep pressure was made there was an extreme diastolic force perceptible; the bruit de soufflet was increased by motion, and was not audible posteriorly; the pulse was regular, about 80 in the minute; the appetite bad; towards the termination of the case there was pain in the right shoulder. The patient died on this day (January 8) in a state between syncope and asphyxia, after expectorating a large quantity of blood. On the preceding day his appearance was very haggard, the tumor was pulsating violently, and, contrary to what is usual in these cases, the pulse was singularly rapid.

When the body was opened, a small quantity of blood was found in the stomach, which had probably been swallowed in the last agonies of life; there was no effusion into any of the serous cavities. The lung was prodigiously gorged with blood, much of which had been poured into the bronchial tubes; the surface of the lung was abraded when it was in contact with the aneurysm. The aneurysm itself was not very large; it was situated immediately between the crura of the diaphragm, between which it passed upwards until it came into contact with the inferior lobe of the lung; the aperture in the artery was in its anterior wall. There was no perforation of the diaphragm by absorption, but the tumor had forced its way upwards between the crura, merely dissecting through cellular connections.

Dr. Stokes concluded by remarking, that there

were three circumstances in this case which rendered it of great value; first, the diagnosis of the aneurysm from symptoms; second, the confirmation of the stethoscopic signs; third, the peculiar mode of termination, which, as he stated at the commencement, had not been previously described by any pathologist.—*Provincial Medical Journal*. March 11, 1842.

## EXPERIMENTS ON THE TORPEDO.

M. Matteucci communicated the results of some new experiments on the torpedo, illustrative of the theory entertained by himself and M. de Blainville on the analogy between muscular contraction and electricity. He introduced a small quantity of the aqueous solution of opium into the stomach of the living torpedo; the tincture of nux vomica was likewise introduced into the stomach of another live torpedo. The two fishes, apparently dead, were afterwards removed from the water, and on their backs were placed two frogs (prepared in the way already described by the author,) and the galvanometer. When the animal, or any part of it, was slightly touched, it contracted, and the torpedo furnished an electrical discharge, although before the experiment it required strong irritation to produce any effect.

The brain of a torpedo, much reduced in strength, was exposed, and an alkaline solution of potash applied on the fourth lobe. The torpedo died, giving forth very strong discharges.

The electrical organ was rapidly removed from a living torpedo, and prepared frogs were placed on the organ. On passing a knife into the organ, and dividing the smallest nervous filaments, the frogs leaped up, sometimes one, sometimes the other, according to the point of the electrical organ, which was cut. I had never before (says the author) seen in so perfect a manner the localised action of nervous filaments, nor had I ever witnessed so clearly the curious action of the electrical lobe of the brain. I received six torpedos, which were brought to me in a state of apparent inanition; the most active infants failed to produce a discharge, for the animals seemed to have been destroyed by the cold. I exposed the brain, and on irritating the fourth lobe I obtained very powerful discharges. I cut up the electrical organ of a live torpedo in all directions, and applied the galvanometer to different points; the direction of the electrical current was invariably from the points nearest the back, towards the lower part of the belly. It is impossible to admit any analogy between the organ and piles, batteries, &c.—*Ibid*, from *Transactions of the Academy of Sciences*.

## STAMMERING.

At a meeting of the Medico-Chirurgical Society of Edinburgh, Jan. 4, 1843, Dr. Abercrombie communicated "Observations on the Impediment of Speech, commonly called Stammering." When Dr. Abercrombie's attention was first directed to the subject the following facts attracted his notice:—

I. He observed that stammerers never stammer in singing.

II. The individual on whom his first observations were made, did not stammer when he was obliged to speak in a louder tone of voice than usual, as when



conversing in the midst of a noisy crowd, or in a carriage on a rough road.

III. The precentor of a church came under his notice, who stammered in common conversation, but showed no hesitation when reading out the line, as it is called, which was done in a peculiar high-pitched tone of voice, such as is usually employed by precentors for that purpose.

IV. He found that stammerers have no difficulty in performing any of those movements of the lips and the tongue, by means of which the consonant sounds are produced, when they are directed to make these movements simply—that is, without any reference to speech.

V. He observed that in some stammerers the difficulty is not confined to the consonant sounds in which the peculiar action of the organs of speech is more directly exerted, but extends to other sounds, in which these organs are little, if at all, concerned, such as the simple aspirated *h*, as in the words *happiness, holiness, &c.* In one individual, indeed, who was treated successfully, he found that he often hesitated at such words as these, long after he had overcome every difficulty respecting the consonants.

By such facts as these he was led to conjecture that the affection does not depend upon any defect in the organs of speech, properly so called; but is rather connected with a deficiency in the management of the voice, and he thought it would be found that, when a stammerer gets into that peculiar state of hesitation which is familiar to every one who has witnessed it, he is endeavouring to speak when he has no voice—that is, when the lungs have become emptied of air, or nearly so.

According to these views, the principles on which the cure of the affection may be accomplished appeared to be the following.—In actually accomplishing a cure, everything depends upon the perseverance of the patient himself after the principles have been explained to him.

I. To direct the attention of the individual to the three distinct parts of which the function of speech consists—viz.

1. A full and continuous current of air proceeding outwards from the lungs.

2. The formation of this into inarticulate sound, or voice, by the action of the larynx.

3. The formation of this into articulate sound, or speech, chiefly by certain movements of the lips and the tongue.

He soon perceives that he has no difficulty in performing any of these actions when they are thus made separate objects of attention; and in this manner he is led to understand that his affection does not depend upon any defect in any of the organs of speech, or a difficulty of performing any of the processes of which the function consists; but in a certain want of harmony among these processes which has grown into a habit. He is easily made to perceive, for example, that he has no difficulty in performing that motion of the lips by which is formed the sound of the letter *b*, then why should we have any difficulty in saying *bee, boy, bell, &c.* When the formation of each letter is thus made a separate object of attention, or a distinct voluntary act, it is remarkable to observe how the difficulty seems to vanish; and, by continued attention in this manner, the habit is gradually broken, in as far as concerns this part of the process.

II. The second and principal part of the treatment is, to exercise the individual in the habit of never attempting to speak without having a FULL AND STRONG CURRENT OF VOICE. He may be made sensible of the

effect of this by making him read in a strong, loud tone of voice, as if he were calling to a person at a distance, or in a tone resembling singing or chanting, or in the peculiar tone of a precentor, in reading out the line, which has been already referred to. When he has thus been made to understand the principles on which the removal of the affection is to be conducted, the farther treatment consists in a course of exercises calculated to give him a full command of his voice, and so to correct the habit which he has acquired, of speaking, or attempting to speak, without sufficient voice. For this purpose he should be made to read aloud several times a-day, from an author whose style is somewhat declamatory. In doing so, he should be made to read in a high-pitched tone, and to stop frequently and take a full breath, so as to have the voice thrown out with a force beyond what is required for ordinary reading or ordinary conversation. With this view it is necessary to make him stop and take a full inspiration much more frequently than would be required by another person; for it is in this part of the process that we are to trace, in a great measure the bad habit he has acquired, and the opposite habit which he is required to cultivate. In particular, when he feels the tendency to hesitate at a word, he is to be taught to stop instantly, take a full breath, and then try it again. He will be immediately sensible of the effect; and a succession of voluntary efforts of this kind will be gradually formed into a habit, calculated to correct the injurious habit, in which, I believe, we are chiefly to trace the pathology of stammering.

In a note appended to this paper, Dr. Abercrombie remarked that, since his observations were written, he had found that the same principle respecting the influence of respiration in this affection had been pointed out by Dr. M'Cormack, of Belfast, in a small volume published in 1828.—*Edin. Monthly Journ.*

#### REMARKS ON THE CALCULI IN ST. GEORGE'S HOSPITAL.

BY DR. BENICE JONES.

The number of specimens submitted to examination was 233. The author's object, from the analysis of these calculi, is to arrive at conclusions with regard to the comparative frequency of different states of the urine in calculous complaints, and thus to obtain practical hints as to the efficacy of remedies intended to alter the secretion, or act upon the stone in the bladder. He presents several tables; and taking 450 states of the urine, inferred from the composition of the calculi, finds that, in 139, it was alkaline, and in 311 acid, to test paper. Omitting from the latter list 59 specimens of oxalate of lime, 252 cases of the uric acid diathesis remain; and in 117 of these no free acid was passed, from which the author concludes that alkalies would have been of no benefit to them, so far as neutralising acidity of the urine was concerned. Taking the cases in which the alkaline concretions prevailed, he infers that in 52 the calculus might have been lessened by the injection of dilute acids; and in 12 the whole calculus might have been removed; while in others to which he refers, disintegration might have been effected. He concludes by describing a calculus in Mr. Cæsar Hawkins' possession, the nucleus of which consists of cystine, and which, from the history, appears to have been formed when the patient was two years and a half old.—*Trans. Royal Med. and Chirurg. Society, from Prov. Journ.*



## URETHROPLASTY.

At the Academy of Medicine, Paris, March 7, 1843, M. Ricord presented a patient on whom he had recently operated for loss of the urethra. The canal had been completely destroyed in its spongy portion by phagedenic chancre; the greater portion of the skin of the penis had also been destroyed by the same sore, and two-thirds of the circumference of the corpora cavernosa as well as the sulcus, indicating the original seat of the urethra, were covered by a thin cicatrix; the urine escaped through an opening in a fold of integument over the scrotum. To remedy this state of things, M. Ricord endeavoured to form a new urethra between the corpora cavernosa and the tissue of the cicatrix. For this purpose he passed a peculiar shaped trochar into the meatus urinarius, and pushed it backwards in the direction of the original urethra and above the cicatrix, until it met a gorget, which had been passed a few lines into and beyond the orifice through which the urine flowed. A silver canula was now introduced through the artificial canal, and allowed to remain in for two hours, when the urine passed freely through the new channel. The penis was enveloped in lint moistened with cold water; there was little tumefaction or inflammation. On the fifth day the canula was replaced by an elastic bougie, and since the 27th of January (the day on which the operation was performed) the size of the bougies has been gradually increased, so as to give a proper diameter to the new canal.—*Prov. Med. Journ.*

## PILULÆ HYDRARG. CUM FERRO.

Dr. G. F. Collier recommends a compound of the sesquioxide of iron and mercury, as preferable to the ordinary blue pill of the pharmacopœia. Its advantages he states are as follows:—It is made in five minutes, the ordinary blue pill requiring a week (in reality, many hours, not days.) The globules are not visible, even by the microscope; it is uniform in its appearance and effects; it makes a smoother pill, retaining its form more permanently; it salivates in a few days in the usual doses, the presence of the iron preventing the wear and tear of the frame under the effects of the mercury, and the powers of life are not so much (scarcely at all) prostrated under its use; it is, consequently, peculiarly eligible for the strumous, irritable, and anemic constitutions. It is prepared by rubbing together one part of the sesquioxide of iron, two of mercury, and three of rose confection, until the mercurial globules cannot be distinguished.—*London Lancet.*

## VALUE OF CARBONIC ACID WITH QUININE IN INTERMITTENT FEVERS.

A physician in a marshy district in the south of France having frequently met with cases of endemic intermittent fevers in which, owing to a spasmodic state of the stomach, the sulphate of quinine becomes inert, has found means to restore its active powers by associating it with carbonic-acid gas. The following preparations are those he recommends with this view:—R. Tartaric Acid, 2½ drachms; Sulph. of Quinine, 1½ grains; rub well together, and add Bicarb. of Soda, 18 grains, and Powdered Sugar ½ drachm. To be taken while effervescing, in half a glass of water. R. Sulph. of Quinine, 12 grains; Tartaric Acid, 1 drachm; Bicarb. of Soda, 1½ drachm, and Powd. Sugar, 1 oz., to be dissolved in a quart of water. Mix first the sugar and water, then the qui-

nine with the tartaric acid; and lastly, the bicarb. of soda; seal hermetically to prevent escape of gas. Dose, a wine-glassful every two hours.—*London Lancet.*

## REVIVAL OF THE ARTS AMONG THE GREEKS.

Dr. Archigenes, a Greek surgeon, of Epibates, in Thrace (Roumelia,) has recently presented to the French Academie de Medicine an instrument which he has invented for operating upon vesico-vaginal fistula. This instrument, which is manufactured by M. Charriere, of Paris, is stated by its originator to preserve all the advantages, avoiding the inconveniences of others for the same purpose, invented by Depierris, Forrestier, and other French surgeons. The short notice we have received of its peculiarities would render its description here meagre or unintelligible.—*Ibid.*

## CELLULAR CYSTICERCUS UNDER THE CONJUNCTIVA.

M. Florent Cunier was called to see a patient who had a small vesicular swelling on the conjunctiva of the right eye, near the cornea, the result of an attack of inflammation following a blow from a butterfly, which had struck against the eye, and left one of its feet in the folds of the membrane. At the time M. Cunier saw it, it was about as large as a pea, and had several enlarged and varicose vessels feeding it; it was not painful, but impeded vision by its encroaching on the cornea. M. Cunier first punctured the vesicle, and the next day dissected it away with a pair of curved scissors. On examining the swelling after it had been withdrawn from the water into which it had been plunged, it was found to represent a transparent, vesicular body, with a swollen extremity, like a caoutchouc bag. When examined under the microscope, it was recognised as a cellular cysticercus, analogous to those that have been already observed in the same part by Baumés, Hœring, and Estling. The four suckers and the double circle of hooks were perfectly distinct. After having separated the worm from the remaining portion of cyst, and allowed it to be in water for two hours, it was found to have folded itself on itself, and looked like a piece of crystalline that had been in water for several days; the oblong spot, spoken of by M. Baumés as consisting of the retracted head and neck, were very distinct.—*Prov. Med. Jour., from Annales d'Oculistique.*

## ADULTERATION OF MILK.

M. Donne presented an instrument which he calls lactoscope, and which indicates the quantity of cream contained in any given specimen of milk. The principle of this instrument depends on a property of milk. It is well known that the dull white color of milk is occasioned by the number of rich globules which it contains; and the greater the number of these globules, the richer is the milk in cream. Now, as the opacity of milk depends on the quantity of globules, the measure of this opacity will give the measure of the richness of the milk. The opacity, however, cannot be appreciated in a fluid; only thin layers will serve for the purpose, and this is effected by the lactoscope. The instrument is composed of two parallel plates of looking-glass, which are brought together or removed from each other as required; the milk is placed between the plates, and the flame of a candle serves to measure the opacity, which is measured off on a graduated circle.—*Trans. Academy of Sciences, Paris, from Prov. Med. Jour.*